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***STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
OCTOBER 24, 2017***

Mr. Chairman and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this legislative hearing of the House Veterans' Affairs Committee. As you know, DAV is a non-profit veterans service organization comprised of 1.3 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. DAV is pleased to offer our views on the bills under consideration by the Committee.

H.R. 1133, Veterans Transplant Coverage Act of 2017

This legislation, if enacted, would require the Secretary to extend health care eligibility through the Department of Veterans Affairs (VA) to a live organ donor before and after conducting a transplant procedure for a qualifying veteran, even if the donor is not eligible for VA health care. The bill also authorizes transplant surgery to be performed at non-VA facilities and be paid for through the Veterans Choice Program, at the discretion of the Secretary.

Currently, enrolled veterans have limited options through the VA health care system when requiring organ transplant surgery. Because there are only 13 VA medical centers that offer this specialized care, many seriously ill veterans are forced to travel great distances, or even move near a VA facility that provides this service in order to receive necessary pre- and post-operative care, and to await a donor match. Some veterans are forced to relocate their families for months at a time with no guarantee that a donor will even be found.

Unfortunately, due to the overall lack of organ donors nationally, and the current statutory constraints in the VA system, many veterans pass away while awaiting donors. Furthermore, due to the expenses involved in traveling while pursuing organ donation through the VA health care system, veterans as well as surviving family members are often left in difficult financial situations.

Extending limited eligibility and care to live organ donors who are not otherwise eligible for VA care could open up additional possibilities for some seriously and terminally ill veterans. Allowing VA to cover the cost of transplantation procedures in non-VA facilities through the Choice program could also alleviate some of the burden and cost that veterans and family

members incur when traveling to distant VA medical centers that perform these life-saving procedures.

DAV does not have a resolution from our membership on this specific proposal; however, we are not opposed to passage of this legislation.

H.R. 2123, the Veterans E-Health and Telemedicine Support or VETS Act of 2017

This bill would enable a VA health care professional licensed, registered, or certified in a state to practice his or her profession at any location in any state, regardless of where the professional or veteran is located, to treat a veteran through telemedicine. If enacted, the bill would permit telemedicine treatment regardless of whether the professional or the patient were physically located in a federally owned facility.

The bill would require VA to report to Congress one year following its implementation on a variety of aspects of the Department's telemedicine program, including patient and provider satisfaction, access, productivity, waiting times and other information related to appointments made and completed through telemedicine.

Because health professional licensure is a state-regulated function, as a national system, VA has experienced barriers in its efforts to broaden the use of telemedicine across state lines. A number of VA telemedicine initiatives have been frustrated because of the interstate restriction. Enactment of this bill would eliminate that barrier, and would promote much greater use of telemedicine, especially in facilities whose treatment populations come from multiple states (Martinsburg, West Virginia—patients from Virginia; Washington, DC—patients from Virginia and Maryland; Pittsburgh, Pennsylvania—patients from Ohio; New York City, New York—patients from New Jersey; Boston, Massachusetts—patients from New Hampshire, Vermont and Maine; Fayetteville, Arkansas—patients from Missouri, Oklahoma, and Kansas, etc.). Enactment of this bill would open the door to VA specialists treating veterans through telemedicine irrespective of state jurisdiction, physical location, or the distance that separates patient from provider (for example, VA specialists in Seattle would use technology in real time to treat VA patients at the VA Outpatient Clinic in Anchorage, Alaska), and should also be highly cost-effective and more convenient for veterans who live at a distance from their VA medical centers, or who must travel long distances for access to basic VA care.

Delegates to our most recent DAV National Convention approved Resolution No. 128. Among other priorities, this resolution calls on VA and Congress to establish and sustain effective telemedicine programs as an aid to veterans' access to VA health care, particularly in the case of rural and remote populations. Our delegates also approved Resolution No. 230, fully supporting the right of rural veterans to be served by VA. This bill is consistent with these resolutions and DAV policy; therefore, DAV strongly supports its enactment and appreciates the sponsors' intention to promote the use of telemedicine in the care and treatment of veterans.

H.R. 2601, Veterans Choice for Transplanted Organs and Recovery Act of 2017

This legislation, if enacted, would allow a veteran in need of organ transplantation who lives more than 100 miles from a VA transplant center to receive hospital care and services related to the required organ transplant at an outside facility that meets the requirements under the Veterans Choice Program.

Under current policy, veterans needing organ transplantation surgery must travel to one of the VA's 13 transplant centers, which requires some seriously ill veterans to travel hundreds of miles not only for the surgery, but also for pre- and post-operative care. A 2014 study published in the Journal of American Medicine found that longer travel distances between a patient's home and transplant center correlated to higher mortality rates.

DAV does not have a specific resolution in regards to this legislation; however, we are not opposed to its passage. Veterans who require organ transplantation but have serious access challenges to receiving that care because they reside far from a VA transplant center should have additional options for necessary life-saving surgery.

H.R. 3642, the Military Sexual Assault Victims Empowerment Act or the Military SAVE Act

This bill would require the VA Secretary to establish a three-year pilot program in five locations to provide non-VA medical care to veterans with conditions related to military sexual trauma (MST). For eligibility, veterans must, in the judgment of a Department mental health professional, have experienced an incident of sexual trauma while serving in the military during active duty, active duty for training or inactive duty training, and reside in an area offering the pilot. Pilot participants would be able to select a non-VA care provider of their choice as long as they accept VA's pay rate for services rendered through VA's Choice Program or an existing contract.

VA would be required to notify all eligible veterans about their opportunity to participate in the pilot and provide "educational referral materials" regarding non-Department providers in the area. Additionally, on a case-by-case basis, VA would be authorized to provide veterans who elect to participate in the community care pilot continued access to that provider until the completion of the episode of care.

The measure would also require VA to survey, at six-month intervals, all eligible veterans at the pilot site who are receiving care for a MST-related condition to determine the quality and effectiveness of VA versus non-VA care. The survey must include information about the differences in wait times, distance to a treatment facility, frequency of appointments, duration of treatment, medication use, access to emergent mental health care services and clinical outcomes. Survey findings must be collected and analyzed by a qualified VA researcher and a final report provided to Congress not later than 60 days before completion of the pilot program.

While this bill's stated goal is to "improve the access to private health care" for MST survivors its more apparent intent appears to be to evaluate quality of care and access to services

for a MST-related condition in VA compared to a non-VA care setting. DAV has no resolution calling for a comparative survey for MST-related care, but we would like to take this opportunity to express our concerns with this bill.

Currently, VA has the authority to send veterans to the private sector for care in cases where VA cannot provide the care needed, cannot provide care in a timely manner, at the recommendation of a VA physician, when there is geographical hardship in commuting to a VA facility, and in cases where the veteran may have a special circumstance or need to be seen outside of the VA. DAV supports veterans access to care in the community in these noted circumstances; however, we want to ensure high quality care and that the non-VA provider has the cultural competency and expertise in treating patients who have experienced sexual trauma during their military service.

VA is well known for its targeted MST-related research, clinical training and specialized treatment for veterans. All enrolled veterans using VA care are screened for MST, and survivors who are in need of mental health care receive tailored treatment plans. In fiscal year 2016, VA provided nearly 1.5 million MST-related outpatient visits to veterans (male and female) who screened positive for MST.

All VA mental health and primary care providers are required to complete MST training to ensure they are sensitive to the unique issues related to sexual trauma and can provide effective treatment to veterans who have experienced MST. According to VA more than 6,300 mental health providers have received extensive training and supervision in the most effective evidence-based psychotherapies (EBP) for PTSD to include Prolonged Exposure and/or Cognitive Processing Therapy. More than 1,800 VA providers have received extensive training and supervision in one of three EBPs for depression. VA reports that veterans who received this specialized treatment have experienced clinically meaningful and significant improvement in their PTSD and depressive symptoms.

By contrast, RAND's *Ready to Serve* national study of therapists who treat PTSD and major depression found that compared to providers affiliated with the VA or the Department of Defense, "a psychotherapist selected from the community is unlikely to have the skills necessary to deliver high quality mental health care to service members or veterans with these conditions." According to the study only 18 percent of Tricare and six percent of non-Tricare community therapists were trained in and used an EBP.

Additionally, VA reports there is a national initiative within the Department to disseminate evidenced-based therapies for mental health conditions related to MST as well as web-based resources, monthly calls with mental health providers and an annual conference for clinicians to ensure they receive up-to-date information about delivery of care options to this population. VA also has a designated coordinator in every VA medical center who serves as the contact person for veterans for MST-related issues and services.

VA's ability to provide high quality care to MST survivors is more than providing specialty treatment; it is also understanding military culture and that this population often has other mental health and physical comorbidities, in addition to an increased likelihood of

experiencing homelessness, substance use disorder and an elevated risk for suicide. VA's comprehensive care model allows providers to address the whole veteran by having an array of health care treatment options, benefits and wraparound services to support them. VA's Vet Center Program, the Veterans Crisis Line and other complementary and alternative care options along with specialized care programs for PTSD, homelessness and substance-use disorders, are just a few ways in which VA coordinates its resources, benefits, and medical services to not only meet the health needs of veterans, but also simultaneously address their psychosocial and economic well-being.

There is no comparable program in the private sector for this population and providers are less likely to have the necessary skills and experience to provide the most effective care and health outcomes for MST survivors. When it comes to caring for this group of veterans, it is essential that they receive the *right* care, at the right time, by a qualified health care provider that is able to deliver effective care and supportive services. Given VA's comprehensive and integrated health care response to military sexual trauma and proven expertise in effectively treating veterans with PTSD or other mental health conditions resulting from MST, we believe these veterans are best served in VA. For these reasons DAV is unable to support this measure.

Draft Bill, to modify the authority of the Secretary of Veterans Affairs to enter into agreements with State homes to provide nursing home care to veterans, to direct the Secretary to carry out a program to increase the number of graduate medical education residency positions of the Department of Veterans Affairs

Section 1 of the draft legislation would amend Section 1745(a) of title 38 to modify VA's authority to enter into provider agreements with State Veterans Homes for the purpose of providing skilled nursing care to certain service-connected veterans. Public Law 109-461 as amended by Public Law 112-154 authorizes VA to pay the "full cost of care" for veterans who require skilled nursing care due to a service-connected disability, or who have a disability rating of 70 percent or greater and are in need of skilled nursing care. Since enactment of these laws, VA has entered into provider agreements with each State Home for the provision of such care to eligible disabled veterans.

However, a few years ago, the Administration made a determination that the use of provider agreements by VA for this program and others in lieu of more burdensome federal contracting requirements was in conflict with federal labor laws. Since that ruling, VA has been prevented from entering into new provider agreements.

This section would provide VA with specific statutory authority to enter into provider agreements with State Veterans Homes to continue providing care to seriously disabled veterans under Section 1745(a), while ensuring that State Veterans Homes fully adhere to federal laws concerning integrity, ethics, fraud, as well as Title VII of the Civil Rights Act of 1964 prohibiting discrimination in hiring. State Veterans Homes would also remain subject to all applicable State labor laws concerning employment discrimination.

DAV supports Section I of the draft legislation in accordance with DAV Resolution No. 062, supporting the State Veterans Homes program, which calls for providing, "...states greater

flexibility in providing long-term supports and services to veterans in State Veterans Homes,” and specifically addresses VA’s ability to “...enter into provider agreements with State Veterans Homes to pay the full cost of care provided to veterans with 70 percent or higher service-connected disabilities or who require nursing home care for service-connected disabilities.”

Section 3 of the draft legislation would provide VA with new authorities to incentivize medical students to fill the 1,500 graduate medical education residency positions created by Public Law 113-146, the Veterans Access, Choice, and Accountability Act of 2014.

Under this section, the Secretary would create a program to provide additional educational assistance to individuals in return for a period of “obligated service” working for the VA health care system. The legislation contains specific penalties for failure to complete the residency program or to fulfill the service obligation to VA.

While DAV supports creating additional financial incentives to help VA recruit, hire and retain high-quality medical professionals, concerns have been raised about whether the requirement for “obligated service” is the most effective manner in which to achieve that goal. The underlying graduate medical education residency program currently does not have such a requirement. Further, this provision lacks specificity regarding the level and type of financial assistance to be provided, as well as the length of the required “obligated service.”

While we support the intent of creating new incentives to bring clinicians into the VA health care system, we believe that further discussion and consideration of alternate incentives should occur before moving forward with this provision.

**Draft Bill, to establish a permanent Veterans Choice Program and
VA Legislative Proposal, the Veteran Coordinated Access and Rewarding
Experiences (CARE) Act**

DAV deeply appreciates the commitment and work of the members and staff of this Committee and the VA for the two draft bills being considered in today’s hearing. Both bills seek to improve veterans’ access to community care by, among other things, consolidating some of VA’s purchased care authorities, ensuring coordination of care and health information sharing. DAV is pleased both bills contain some of our recommendations to reform the VA health care system while preserving and strengthening it so that DAV members and all eligible veterans may continue to enjoy the unique benefits and vital services VA provides well into the future.

A couple of years ago, DAV and our *Independent Budget* (IB) partners developed a comprehensive framework to reform VA health care based on the principle that it is the responsibility of the federal government to ensure that disabled veterans have proper access to the full array of benefits, services and supports promised to them by a grateful nation. In order to achieve this goal, our comprehensive framework has four pillars—Restructure, Redesign, Realign, and Reform. We offer our views on specific provisions of these draft bills that we believe fit within this framework and recommend it be part of the final legislation this Committee passes to reform VA health care.

- I. **Restructure our nation's system for delivering health care to veterans, relying not just on a federal VA and a separate private sector, but instead creating local Veteran-Centered Integrated Health Care Networks that optimize the strengths of all health care resources to seamlessly integrate community care *into* the VA system to provide a full continuum of care for veterans.**

Veteran-Centered Integrated Health Care Networks

Veteran-Centered Integrated Health Care Networks were proposed in response to fragmented care delivery by providing a coordinated continuum of services—from wellness and preventive services to urgent care, inpatient care, outpatient care, extended care and hospice—to a defined veteran patient population. The goal of improving veterans health outcomes at lower cost by operating effectively and efficiently greatly depends on the performance level and degree of integration.

Degrees of such integrations can be measured by the use of evidence-based disease management, formularies, continuum of care and mix of available services, and the use of technology such as information systems and integration level as well as real time central medical records.

CARE Act: To this end, the CARE Act provides little concrete description as to how Veteran-Centered Integrated Health Care Networks will be created, implemented, administered, overseen and how to determine if they are successful.

Veterans Choice Program (VCP) draft bill: The VCP draft bill would establish the Veterans Choice Program under which VA would, subject to appropriations and the election of veterans, provide hospital care and medical services to eligible veterans through contracts and agreements with non-VA providers. The Secretary would be required to establish regional networks of providers and may enter into one or more contracts to manage the operations of these networks.

To assure quality throughout the network of providers contemplated under the VCP draft bill, DAV recommends that any contracts made by the VA health care system with non-Department providers contain standards and requirements that allow VA to ensure these providers are able to uphold at least the same quality of care available at medical facilities within the Department, allowing the Secretary to measure, monitor and thereby be accountable for, care delivered through non-VA providers. VA, and not the network provider, should be held accountable for coordinating the veteran's care (1703A(a)(3), (b), (c), (d)(5)(A),(g)) and the ability to generate efficiencies (1703A(k)) that reduce costs (1703A(d-f), Sec. 102(a)(1)) while meeting certain quality, or care metrics (1703A(i)).

Such standards would include all matters related to scheduling and timely access to care standards, quality of care standards, and health information sharing capability. This proposed change directs the Secretary to use the Veterans Choice Program as it uses Department facilities and employees to furnish care to ill and injured veterans (see 38 USC 1710).

From a veteran patient’s perspective, a Veteran-Centered Integrated Health Care Network should provide veterans information they would need to make an informed decision. For example, information about the quality of the community providers in this network will give veterans the ability to discern between those community providers that are more knowledgeable about the veteran experience and their unique needs, information about the satisfaction rating from other veterans who have seen that provider, and whether there is a good working relationship with the VA that facilitates care coordination.

The Veteran-Centered Integrated Health Care Network would create and preserve the kind of community-VA provider partnership that mirrors the care our members value most in the VA health care system.

To ensure formation of the local Veteran-Centered Integrated Health Care Networks requires the function of a high performing network. Our framework places VA as the coordinator and principal provider of care, which we discuss immediately below. VA’s primary care (medical home) model with integrated mental health care, is more likely to prevent and treat conditions unique to or more prevalent among veterans, particularly those with disabilities or chronic conditions, but is not a requirement of non-VA primary care providers, which is a concern for DAV.

II. Redesign the systems and procedures by which veterans access their health care with the goal of expanding actual, high-quality, timely options; rather than just giving them hollow choices.

Care Coordination

DAV strongly urges the Committee to discontinue the current arrangement under the Choice program that has effectively removed a critical part of the care coordination responsibility away from VA front-line clinicians. VA Community Health Nurse Coordinators are the case managers and coordinators of care and work with the veteran's health care team to provide for the veteran patient's medical, nursing, emotional, social and rehabilitative needs as close as possible to or in the veteran’s home.

While VA Community Health Nurse Coordinators are now better able to exercise their clinical authority due to the reorganization under Section 106 of Public Law 113-146, the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), they are frustrated having lost their ability under the current Choice program to act as a liaison between community providers and VA and as an advocate for their veteran patients—who themselves have unsuccessfully tried to exercise their Choice option and asked for assistance from their VA nurse coordinator—to get the care they need in the community.

CARE Act: We strongly recommend that language be added to the CARE Act to ensure VA remains the coordinator of veterans’ care, especially if that care is provided in the community and paid for by the Department.

VCP draft bill: While DAV applauds the VCP draft bill for its appreciation of the medical home model featuring assignment to a primary care team or provider, we strongly recommend the Committee ensure VA remains the coordinator of veterans' care.

We further recommend the required assignment of a veteran to a dedicated VA primary care provider or VA Patient-Aligned Care Team (PACT) be made at the time the veteran seeks care, not at enrollment, and not necessarily for all enrolled veterans. We believe the current proposal will lead to gross misalignment of resources because not all veterans who enroll seek care from VA. In addition, highly disabled service-connected veterans have never been required to enroll for health care.

Many veterans have several types of health insurance and have defined utilization patterns inside of VA and with other providers. If all are assigned to VA primary or Choice providers, would veterans be required to use them as gatekeepers when they already have a primary care provider elsewhere and really just need a new prosthetic limb or wheelchair? To relieve waiting times, one medical center looked at the effect of allowing veterans to self-refer to audiology for services related to hearing loss, rather than requiring a primary care provider's referral. During the previous Administration, this change was identified as a "best practice" for relieving waiting times and increasing access. DAV hopes that VA will use its utilization data to identify those veterans who are most reliant upon it for care and make these assignments to PCPs and PACTs, and case management as appropriate. Less reliant veteran patients are accounted for in VA's resource allocation methodologies, but may not require assignment to a regular primary care provider. In addition, VA should give veterans an opportunity to elect a new provider if there are extenuating circumstances such as a new VA resource (such as a community-based outpatient clinic) becomes available, their medical condition changes or their transportation provider is no longer available. Veterans should also be able to leave an assigned network provider if that provider can no longer provide timely access to care.

The proposed section 1703A(b)(1)(B)(iii) in the VCP draft bill requires VA to ensure an "eligible veteran is not simultaneously assigned to more than one patient-aligned care team or dedicated primary care provider..." We remind Congress and VA in executing this provision of the Department's current policy regarding traveling veterans who are assigned to a PACT at the veteran's preferred facility as well as assignment to a PACT at an alternate facility for their annual extended travel. We urge the Committee to ensure this patient-provider relationship is not adversely affected.

Telemedicine:

CARE Draft Bill: We support the intent of section 301 of this draft measure. DAV has previously testified that, as a national health care provider making extensive use of telemedicine, VA must ensure that its providers' state licensure is legally protected if they use technology to provide medical services across state lines.

We note H.R. 2123, the Veterans E-Health and Telemedicine Support or VETS Act of 2017, is on today's agenda and based on previous testimony from VA on a similar bill, section 2(a) would remove the barriers that might be imposed by local licensure laws of the places where

the patient or the covered health care professional are located, or the state of licensure of the health care professional. Further, section 2(a) would make clear that any telemedicine services that involve prescribing controlled substances would have to be provided in accordance with the Controlled Substances Act. We refer the Committee to our discussion on this authority under H.R. 2123 and urge its swift and favorable action.

Use of Veterans Health Information:

VCP Draft Bill: The disclosing of medical information under section 202 was discussed before the Subcommittee at the June 23, 2016 legislative hearing on H.R. 5162, the Vet Connect Act of 2017.

We testified that “DAV understands and supports increased use and appropriate sharing of health data; however, veteran patients also want to be assured of the privacy and security provided for protected information. We urge the committee and the sponsor of this legislation strike a more balanced policy between the competing aims of sharing data and protecting privacy. We recommend such broad language be amended to affect only shared patients and only for the purpose of completing a treatment plan to which the veteran patient has agreed.” Accordingly we recommend language be inserted after line 16:

“(II) An entity to which a record is disclosed under this subparagraph may not redisclose or use such record for a purpose other than that for which the disclosure was made.”

Consolidation of Existing Authorities

VA has a number of statutory authorities, programs, and other methods for purchasing community care. The various methods for receiving community care have conflicting structures, responsibilities, ownership, and management, with different application at the local and national levels and has led to inefficient implementation and significant confusion among veterans, community providers, VA providers, and staff.

We support the consolidation of VA’s purchase care authorities to the maximum extent possible to realize the benefits of standardized authorities and programs, which have differing requirements and processes for key components, including, but not limited to, eligibility criteria and eligibility determinations; referrals and authorizations; provider credentialing and network development; health care and health information coordination; reimbursement/payment rates, and; claims management.

CARE Act: This bill proposes to consolidate existing community care authorities under section 221 of the Act but is limited to Section 1703, dental care under Section 1712, counseling and related mental health services under Section 1712A, burial under Section 2303, and care for ill Persian Gulf War veterans under Section 1117 (note). This consolidation is a far cry from the planned consolidation of Section 7409 (Scarce Medical Resources), Project ARCH, Section 403 of Public Law 110-387 (as amended), the Pilot Program of Assisted Living for Veterans with TBI, Section 1705 of Public Law 110-181(as amended), and emergency care under Sections 1725 and 1728 and the proposal to authorize VA to pay the reasonable costs of urgent care.

Moreover, it appears section 201 of the CARE Act would impose another eligibility criteria on those purchased care authorities under section 211.

Veterans Care Agreements¹

We support the establishment of provider agreements to meet the need for this authority to be enacted into law without delay. VA purchases a broad spectrum of medical and extended services from private sector providers for veterans, their families and survivors under specific but fragmented authorities. These authorities have in some cases created confusion and uncertainty among ill and injured veterans and private providers in their community.

CARE Act: Section 101 the CARE Act would allow VA to use provider agreements to purchase medical care and services in certain circumstances. The bill appears to preserve key protections found in the contracts based on the Federal and VA Acquisition Regulations including protections against waste, fraud and abuse. It intends to streamline and speed the business process for purchasing care for an individual veteran that is not easily accomplished through a more complex contract with a community provider, and thus be more appealing to some providers.

We understand this proposal is not intended to supplant long-standing regional and national contractual and sharing agreements, which is helping to build VA's extended network of community providers. Rather, this authority is intended to play a supporting role in specific situations when, for a variety of legitimate reasons, needed care cannot be purchased through existing contracts or sharing agreements.

Since VA's current authority to enter into provider agreements under section 101(d) of the VACAA, is proposed to be terminated after September 30, 2018, under section 501 of the CARE Act, we believe the effective dates for both sections must be coordinated and favorably considered.

Furthermore, we believe under Veteran Care Agreements, extended home- and community-based care and services will be provided to severely ill and injured veterans and aging veterans with chronic conditions. For this patient population, it is essential that the care and services they receive be carefully coordinated. We therefore recommend language be included requiring care coordination to realize the best health outcomes and achieve veterans' health goals.

We appreciate language in the CARE Act intended to improve VA's administrative functions, business practices and employment of data analytics to ensure the purchases are cost effective, preserve agency interests, and enhances the level of service VA directly provides veterans.

VCP Draft Bill: While VA would remain the primary source of care for veterans with network providers serving in a back-up role, there will be some instances likely in highly rural or

¹ <https://www.dav.org/wp-content/uploads/Atizado20150603.pdf>

medically underserved areas where sole practitioners who cannot meet the same standards as network providers are the only available health care resource. We support the establishment of Veterans Care Agreements as a necessary authority to furnish care within the new model this draft develops.

Because this draft bill would not bar an eligible provider from participating as a network provider under 1703A as well as Veteran Care Agreements, we recommend language be included to address the potential for these “dual-participating” community providers to not confuse the authority for receiving referrals which may result in their sending claims to the wrong payer (VA vs. Network Manager).

Community Care Eligibility

For veteran patients, waiting for a health service begins when the veteran and the appropriate clinician agree to a service, and when the veteran is ready and available to receive it. However, we believe it is time to move towards a health care delivery system that keeps clinical decisions about when and where to receive care between a veteran and his or her doctor – without bureaucrats, regulations or legislation getting in the way.

CARE Act: DAV supports the approach under Section 201 of the CARE Act to determine a veteran’s eligibility to elect to receive care in the community. However, there is no remediation plan included in this draft bill that would reinforce the need for community care to supplement rather than supplant the VA health care system. We discuss this aspect in greater detail under “Reform VA's culture.”

VCP Draft Bill: DAV supports this draft bill’s elimination of some of the arbitrary restrictions such as distance and waiting times that currently limit eligibility for community care. Instead, VA, to the extent that resources allow, would be required to make such a determination upon enrolling a veteran for care. Under this bill, enrollment would continue within VA facilities until such time that the Secretary determines VA can no longer assign veterans to primary care providers due to a shortage of health care professionals. At that time, VA would provide veterans with a list of private providers from which to choose. VA would reassess its internal capacity to enroll veterans with a primary care provider on an annual basis.

We are, however, concerned that this system of enrollment may be used to lock veterans out of the VA healthcare system should resources for community care be exhausted. It is also unclear if VA would use priority groups established in 38 USC 1705 for enrollment to primary care providers to ensure that service-connected veterans are never denied care. We also again note that service-connected veterans with conditions rated at 50 percent or more are not required to enroll for care, but should never be locked out of the system because they are not assigned to a primary care provider.

State Veterans Homes

DAV has previously raised concern when Congress considered legislation restructuring VA's relationship with non-VA community providers as it affects provider agreements with community providers and State Veterans Homes specifically.

As you know, it took several years, two public laws (Public Law 109-461 and Public Law 112-154) and an Interim Final Rule (RIN 2900-AO57) to achieve Congress' original intent of offering the most severely disabled veterans the option to receive extended care at State Veterans Homes. As the Committee moves forward, it is important to ensure that any legislation that addresses VA's provider agreement authority with community providers does not modify, diminish, endanger or eliminate State Veterans Homes existing provider agreements authorizing them to provide these critical long-term care services to thousands of severely injured and ill veterans.

We direct the Committee to our discussion of the other draft bill being considered by the Committee to modify VA's authority to enter into agreements with State homes to provide nursing home care to veterans.

Emergency and Urgent Care

DAV continues to recommend making urgent care part of VA's medical benefits package and to better integrate emergency and urgent care with the overall health care delivery system. DAV believes a health care benefit package is not complete without effective provisions to administer and furnish both urgent and emergency care.

We have raised the need to address the eligibility and payment issues that veterans and community providers face regarding emergency care, and this Committee is aware of our organization's long-standing position opposing any and all copayments imposed on veterans and supporting legislation reducing the copay amount.

CARE Act: We therefore oppose the imposition of care copayments had veterans sought this type of care at VA medical facilities.

DAV also opposes the provision that would force veterans to pay copayments while their health insurance reimburses VA for emergency or urgent care. VA should be applauded and allowed to continue its current practice of offsetting a veteran's copayment debt with monies VA receives from billing the veteran's health insurance plan.

VCP Draft Bill: DAV supports the draft bill's emergency transportation benefit, but regrets that its authors did not address the ongoing problems that occur with emergency care or establish a benefit for urgent care. An urgent care benefit could limit the number of veterans using emergency care for lack of a better option. About half of all emergency care users claim that they sought care in that setting because their regular source of care was not available. We urge the bill authors to address these issues.

Emergency Care Eligibility

Carrying out the multiple and complex authorities² for VA to pay or reimburse emergency care under title 38 are a source of continuous complaints and can drive ill and injured veterans and their families to financial ruin.

According to VA, “In FY 2014, approximately 30 percent of the 2.9 million emergency treatment claims filed with VA were denied, amounting to \$2.6 billion in billed charges that reverted to Veterans and their [Other Health Insurance]. Many of these denials are the result of inconsistent application of the “prudent layperson” standard from claim to claim and confusion among Veterans about when they are eligible to receive emergency treatment through community care.”

To address the inconsistent application of the prudent layperson standard, DAV recommended the “emergency condition” under title 38 be defined as follows:

"A medical [or behavioral] condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs. With respect to a pregnant woman who is having contractions that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child."

We also recommend a change to the current requirement for veterans to have received VA care within the last 24-months prior to receiving emergency care in the community to be eligible for VA’s emergency care benefit. This requirement unduly places veterans at risk of financial ruin and discriminates against otherwise healthy veterans who need not seek care at least once every 24 months, yet is required to make an otherwise unnecessary medical appointment in order to be eligible for payment or reimbursement for non-VA emergency treatment. We urge the Committee provide greater flexibility by including an exemption authority to the 24-month requirement for this and other unforeseen circumstances.

III. Realign the provision and allocation of VA's resources so that they fully meet our national and sacred obligation to make whole those who have served.

Revenue Enhancing Provisions

DAV believes all service-connected disabled veterans should not be compelled to pay for their own care according to DAV Resolution No. 115, which calls for the reduction or elimination of any and all veterans’ co-sharing requirements

² 38 U.S.C. §§ 1703, 1725 and 1728

CARE Act: DAV adamantly opposes any and all provisions in this measure that would effectively offset appropriated funds for VA medical care. These proposals can be found in sections 121, 131, 132 and 503, which includes the proposal to take an estimated \$2.7 billion over 10 years from service-connected disabled veterans and their survivors based on the 10-year round down of cost-of-living adjustments for veterans benefits.

DAV is opposed to this rounding down provision. Veterans and their survivors rely on their compensation for essential purchases such as food, shelter, utilities and transportation. It also enables them to maintain a marginally higher quality of life.

The co-authors of the IB, DAV along with Paralyzed Veterans of America and Veterans of Foreign Wars, sent a letter to this Committee on May 24, 2017, stating “rounding down veterans’ COLAs unfairly targets disabled veterans, their dependents and survivors to save the government money or offset the cost of other federal programs. The cumulative effect of this provision of law would, in essence, levy a 10-year tax on disabled veterans and their survivors, reducing their income each year. When multiplied by the number of disabled veterans and recipients of Dependency and Indemnity Compensation or DIC, hundreds of millions of dollars would be siphoned from these deserving individuals annually. All totaled, VA estimates, this proposed COLA round down would cost beneficiaries close to \$2.7 billion over 10 years.”

Equally objectionable is the proposed requirement to charge veterans for the care they receive from VA. This provision seeks to improve VA’s ability to receive information the agency requires to identify and receive reimbursements from a veteran’s health plan. Such a heavy handed approach appears prejudicial considering insurance identification is only one of multiple elements across VA’s revenue cycle to include accurate insurance verification, authorization, utilization management, claims processing, accounts receivable, and payor relations. We note there are no other provisions in the CARE Act requiring specific actions be taken to improve VA’s responsibility in this area of its revenue cycle.

VCP Draft Bill: We oppose subsection (f) of Section 1703A, and Section 203 and recommend both provisions be stricken. Section 1703A, subsection (f) would require certain service-connected disabled veterans to pay VA copayments for care received under the proposed Veterans Choice Program. Section 203 proposes to eliminate VA’s current practice of extinguishing veterans copayment debt from any third-party reimbursements received from that veteran’s health plan.

Veterans, especially those who incur disabilities during or as a result of military service, have already made their payments for health care through their service and sacrifice. We believe the citizens of a grateful nation want our government to fully honor our moral obligation to care for ill and injured veterans and generously provide them benefits and health care entirely without charge.

Funding Flexibility

CARE Act: Viewed together, sections 211, 501 and 502 of the CARE Act would eliminate the current authority to furnish veterans medical care in the community through the

Veterans Choice Program, add \$4 billion of what appears to be no-year mandatory funds into the account designated by Section 802 of the VACAA to be used solely for care in the community.

We are concerned this proposal does not provide the funding flexibility contemplated under VA's own CARE Plan Consolidation that state, "in future budget requests, [VA] will request that Congress appropriate budget authority to this account in the annual appropriations act. The account, which will be known as the 'Community Care' account, will be the *sole source of funding for care that VA provides to Veterans through community providers*. Separating the funding of Veteran community care from the current VA hospital care and medical service funding will require local leaders to set a clear funding level and actively manage community care." (Emphasis added.)

Recording Obligations at Payment

VHA must adhere to certain business standards and practices when obligating funds for a variety of goods and services, including purchased outpatient, inpatient and extended care, and other health care related goods and services. To ensure it does not overspend, funds must be available to cover obligations and expenditures *prior* to entering into an agreement to purchase care and services.

To accomplish this, VHA estimates the amount of funds required for such purchase or obligation and payment, verifies that funds are available prior to recording the obligation in the financial system, monitor all transactions, certify goods and services were received prior to approving payments, and close any remaining balances within 30 days following the end of the month or fiscal year, in which all expected activity has been completed.

In this process it has been found VHA's process has led to overestimation of funds needed to pay for approved purchases of non-VA care. VA's Office of Inspector General found (VAOIG) in 2016 that VHA did not have a performance improvement plan for obligation management, did not have adequate tools to accurately estimate costs of goods and services, and did not routinely adjust cost-estimates of obligations to reflect better estimates of potential costs.

However, VAOIG also found that the VACAA effectively prohibited VHA from using no-year funds for non-VA care and services, which put all over-obligated funds at risk of not being available for any purpose.

We understand the desire to avoid over obligating no-year funds, which delays the availability to use these funds and puts single-year funds at risk of not being used due to expiration of the appropriation. However, the proposed solution to record obligations at payment may put VHA at greater risk of underestimating obligations and thus overspending, the implication of which is concerning to DAV.

Unless appropriate monitoring and controls are in place to protect against the risk of overspending, community care may begin to supplant rather than supplement the VA health care system.

The other option is to improve VA's current processes, systems, and data. It should be noted that VAOIG found certain VHA medical facilities that thoroughly analyzed the historical costs of previous non-VA care authorizations, while time-consuming due to lack of standard data systems and average cost calculation procedures, produced reasonably accurate cost tables. Automating manual reconciliation is also necessary to timely release unobligated funds for use.

We believe the proposed sections 112-114 in the CARE Act to reform its provider payment rates, claims and payment processing would serve to help VHA's ability to more accurately estimate cost of care over time. The general lack of automation and refinement of estimations will persist if not address legislatively.

Claims Processing and Payment

VA's processing of claims has been a significant weakness to the Department's community care programs resulting in costlier care, inappropriate billing of veterans and strained partnerships with community providers. Government Accountability Office reports throughout the years have consistently highlighted disturbing limitations in the Department's claims processing system as having unnecessary manual operations rather than automatically applying relevant information and criteria to determine whether claims are eligible for payment and notifying veterans and community providers about the results of the determination, payment, and appeal procedures.

Many veterans worry about claims that are not paid promptly or are left unpaid, leaving them in a difficult position of trying to get claims paid or be put into collections. These delays or denials create an environment where community providers are hesitant to partner with VA for fear they will not be paid for services provided. Hospitals and community providers have also expressed concern that prompt payment laws do not apply to care that is provided to veterans if they do not have a contract with VA. We have also heard complaints from veterans regarding section 101(e) of the current Choice program, which places on them greater financial burden and emotional stress while trying to recover from injuries and illnesses. We believe the responsibility of the government as first-payer and prompt payer for care and services should be reaffirmed.

CARE Act: DAV supports provisions that would improve VA's timely processing of claims and payment to community providers, including applying the prompt payment act, govern claims management and payments to community providers, and would set a firm date after which VA would not accept claims in other than electronic form. Sections 112-114 would mandate the establishment of an electronic interface to enable private providers to submit electronic claims as required by the section. To further strengthen this proposal, we recommend adding certain provisions requiring VA be primarily responsible for payment of all goods and services, and that equivalent protections for veterans proposed in Section 101(h) be provided under Subtitle B.

VCP Draft Bill: DAV is pleased that the draft bill takes steps to address claims processing and urges the Committee to take immediate action to protect veterans from suffering the consequences of VA's late payments for their care.

IV. Reform VA's culture to ensure that there is sufficient transparency and accountability to the veterans this system is intended to serve.

Beginning on October 1, 2014, the VACAA transferred Non-VA Medical Care (NVMC) Program payment responsibilities from local medical facilities to the Veterans Health Administration's (VHA) Chief Business Office and separated NVMC funding from other VHA Medical Services appropriation funds. We believe it is beneficial to require, rather than make discretionary, the transfer of funds and payment of services to VHA's Office of Community Care. This would help ensure transparency and accountability to a single entity when conducting oversight.

We also strongly urge the Committee to preserve the organizational model required in Section 106 of VACAA in any future consolidation of VA's purchased care authorities. Section 106 effectively created a "wall" that separated the financial and clinical operations of the current Choice program, which better insulated front-line clinicians, such as VA Community Health Nurse Coordinators, social workers, or other VA health care professionals against the fiscal pressures that have been known to sway clinical decisions and delay or deny community care to veterans.

VCP Draft Bill: DAV supports efforts within the draft bill that would better assure that VA networks within the Veterans Choice Program are held accountable for outcomes including quality of care, care coordination, access, and costs, but recommend that the bill address adding standards to allow VA to measure and monitor to their contracts with network providers.

Moreover, in managing resources, capabilities and capacities of the VA health care system, DAV believes the development of integrated community networks must be based on dynamic demand and capacity analysis, which would include modeling of the need to expand, contract, or relocate VA facilities. Local stakeholder input would be essential to ensure that local health care coverage would not be negatively affected by any facility realignment.

Clinical Appeals

VA's Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care clearly indicates, "a clinical appeals process will be available to Veterans who do not agree with the clinical referral decision of their providers. This clinical appeals process will focus on reaching agreement at the care team level, but if disagreements cannot be resolved at that level, an additional level of appeal will be available. Veterans will have a single point of contact for appeals and an opportunity to be heard at each step. Appeals will be timely based on clinical need." No such provision exists in either the CARE Act or VCP draft bill.

CARE Act and VCP Draft Bill: It is unconscionable that it is more important to propose statutory language requiring a procedure in both draft bills for community providers to be able to appeal a decision by VA, but does not propose similar language for veterans to appeal clinical decisions by VA.

We believe statutory language should be included in any legislation proposing to reform the VA health care system requiring the Department to establish by regulation a process for veterans to appeal a VA clinical decision.

DAV agrees with the Commission on Care that VA must ensure veterans have access to a fair and effective appeals process, just like other federal health beneficiaries. At a minimum, VA must assure veterans access to a uniform process with decisions made within clearly defined timelines at different points of the process. Most federal health beneficiaries have a right to an external review at their discretion and veterans should also be allowed this review at the veteran's discretion rather than that of the hospital or VISN director. We understand that VA has convened an interdisciplinary group to review this process, but these are minimal standards that ensure a veteran of due process.

Supplementing the VA Health Care System:

CARE Act: We are disappointed this draft bill does not propose any sort of demand and capacity analysis to ensure community care serves to supplement and not supplant the VA health care system.

VCP Draft Bill: We support the VCP draft bill's efforts to assess capacity in VA and the private sector. To strengthen the proposed section 1703(A)(k), we recommend a more comprehensive evaluation of VA's internal capacity with discrete language in the identification of existing gaps under (A) including:

- Considerations of capital and human capital needs and planning. Capital planning should include meeting new, renovated or replacement space needs, and the orderly disposal of unused, unneeded property.
- A plan to remedy such gaps should also be required in the assessment—including identifying necessary resources to timely close such gaps.

We also refer the Committee to our testimony of October 12, 2017 regarding the asset review and infrastructure draft legislation for additional recommendations and concerns related to demand and capacity analysis.

In forecasting for capacity and commercial market assessment, the proposed section 1703(A)(k)(1)(c) calls for the annual capacity and commercial market assessments to have "(C) forecast, based on future projections rather than historical trends, both the short- and long-term demand in furnishing care or services at such Veterans Integrated Service Network and medical facility and assess how such demand affects the needs to use such network providers."

Demand forecasting can help predict trends for at least three years, but not much longer than five years out. For staffing demand one generally looks at the primary service area population, its market share and out-of-area draw to determine its potential patient volume, as well as considering assumptions such as a population growth and technology development to

help calculate how many physicians would be needed to treat that population to estimate potential physician demand.

We also recommend language indicating such forecasts include valid and reliable historical data.

DAV is concerned that this system of enrollment may be used to lock veterans out of the system should resources for community care be expended. Also DAV is unclear if VA would use priority groups established in 38 USC 1705 for enrollment to primary care providers to ensure that service-connected veterans are never denied care. We also again note that service-connected veterans with conditions rated at 50 percent or more are not required to enroll for care, but should never be locked out of the system because they are not assigned to a primary care provider.

Ensure entitlement for compensation for negligent care:

VCP Draft Bill: The proposed section 1703A(b)(2)(C) would allow a network provider to practice specialty care in a Department facility or Department provider to practice specialty care in a network provider facility.

DAV recommends language extending entitlement, in these instances, to compensation under 38 USC, section 1151, which in general terms provides that veterans' disability or death as a result of negligent treatment furnished by VA, and not the result of such veteran's own willful misconduct, shall be compensated as if their disability or death are service-connected.

Discussion Draft on title 38, United States Code, appointment, compensation, performance management, and accountability system for senior executive leaders in the Department of Veterans Affairs.

Delegates to our most recent national convention passed two resolutions that may be relevant to this informal "discussion" proposal. DAV Resolution No. 126 calls for modernization of the VA human resources management system to enable VA to compete for, recruit and retain the types and quality of VA employees needed to provide comprehensive health care services to sick and disabled veterans. DAV Resolution No. 214 calls for meaningful accountability measures, but with due process, for employees of the VA—by requiring that any legislation changing the existing employment protections in VA must strike a balance between holding civil servants accountable for their performance, while maintaining VA as an employer of choice for the best and brightest.

The discussion draft would apply personnel laws for Senior Executive Service (SES) members now working under title 5, United States Code, which covers most civil servants, to title 38, which allows greater pay flexibility to provide more competitive wages. Hiring under title 38 would also give the Secretary more authority to expedite hiring. These are key issues when competing against other federal agencies and the private sector for top talent. DAV supports the intent of these provisions.

However, there may be some issues when hiring individuals under title 38, which is generally reserved for personnel in health-related fields, and applying those standards to those who would lead the Veterans Benefits Administration, National Cemetery Administration, and VA staff offices. In addition, while the proposed reform would allow expedited SES hiring, DAV asks the Committee to carefully consider whether the proposed executive compensation, which would still lag far behind that of chief executives in private sector health care, is nearly sufficient to offset the new risks being created by other parts of this proposal.

In the final analysis, these individuals would serve at the pleasure of the VA Secretary, with little protection that is now available under current law to guarantee their status under title 5 to appropriately protect their due process rights and provide them retreat rights to lower-level assignments and to insulate them from politically motivated decisions—all hallmarks of the origins of the SES as envisioned in the Civil Service Reform Act of 1978. That act established the SES, the Merit Systems Protection Board, and created an array of procedures and requirements that govern the entirety of the SES program and many other aspects of federal personnel law.

Mr. Chairman, DAV and our members urge serious reform of the VA health care system to address access problems while preserving the strengths of the system and its unique model of care. We appreciate this Committee's hard work and are pleased that many of our recommendations have been incorporated into the measures under consideration today so that veterans will have more options to receive timely, high-quality care closer to home.

Draft Bill Study on the Veterans Crisis Line

This bill seeks to authorize a study on the efficacy of the Veterans Crisis Line (VCL) during the five-year period beginning January 1, 2014. Information that is to be collected includes the number of VCL users who, after contacting the VCL and speaking to a suicide prevention specialist, begin and continue to receive health care furnished by the Secretary and those that do not; the number of veterans that begin care, but do not continue; the number of veterans who call the VCL, but have not previously received care from the Secretary; and those that have previously received such services in addition to a number of other data points regarding VCL use and suicide.

DAV Resolution No. 245, adopted by our members during our most recent National Convention, supports improvements in data collection and reporting relative to suicide prevention; therefore, DAV supports the intent of this bill. However, we want to ensure the data collection effort proposed in the bill does not impinge upon the mission of the VCL—to help veterans in crisis and prevention of suicide.

The VCL is a vital tool that provides veterans several ways of interacting with a qualified suicide prevention specialist. Veterans are able to call the VCL 24 hours a day, 7 days a week to receive high-quality prevention and crisis intervention services. The VCL has helped many vulnerable veterans in crisis averaging more than 500,000 calls per year. Since its inception, it has answered over 2.3 million calls, made over 289,000 chat connections, and completed over

55,000 texts resulting in over 61,000 dispatches of emergency service to callers in imminent suicidal crisis.

While we appreciate the desire to evaluate the effectiveness of the VCL, we also understand that many veterans utilize the VCL with the expectation that their call will be confidential. According to VA, only the responder is able to see his or her information, and the information will not be shared unless permission is obtained from the veteran indicating they would like contact after the call, chat or text message; or if the veteran provides their consent to release information for other purposes. Only in cases of imminent danger will a veteran's location and other relative information be shared to facilitate rescue efforts that are coordinated with local officials. Veterans experiencing crisis are already in distress and at their most vulnerable. The stigma associated with mental health, and needing help is sometimes enough to keep veterans from reaching out to receive the help they need. DAV understands the intent of this draft bill is to gather helpful information to improve or enhance VCL services for veterans; however, we urge the Committee to work with VA to determine if and what information is already being collected and analyzed to monitor the effectiveness of the program as it relates to the provisions in the draft measure. Additionally, it is not clear if all the information to be collected will be available based on the notes from the crisis intervention specialist and a subsequent record review or if the VCL specialist taking the call will need to ask the caller if they can contact them at a later date to ask follow-up questions.

Data collection for the purpose of improving the effectiveness of the program may not qualify as being in the best interest of the veteran. The need to collect information cannot outweigh the primary mission of the VCL—crisis intervention and saving lives. In any case, we recommend a mental health provider be consulted about these sensitive issues prior to moving forward with the bill.

Thank you for inviting DAV to testify today. We would be pleased to further discuss any of the issues raised by our testimony, to provide the Committee additional views, or to respond to specific questions from you or other Members.